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ABSTRACT

The need for mental health services coordination is discussed in this report. It is noted that, without coordination, government units and service providers can operate independently and in competition with one another. The move to deinstitutionalization is discussed, including the lack of service coordination resulting from this move and the failure of deinstitutionalization to meet the needs of the seriously mentally ill. Funding practices which encourage uncoordinated, incomplete care are reviewed. Legislative guidelines to ensure coordinated care are described and include such things as requiring interagency agreements, identifying coordination priorities, and instituting a no-refusal policy among all system elements. Particular state laws for identifying and combating coordination problems are presented. Future funding and service implications for state and local government are discussed. Case studies from Missouri and Pennsylvania are presented. References are listed. (ABL)

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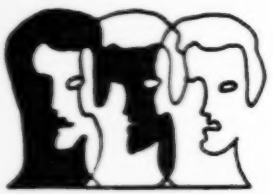

MENTAL HEALTH PROJECT

Human Resources Series

MENTAL HEALTH SERVICES COORDINATION:

WORKING TOWARDS UTOPIA

by

Andrea Paterson

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MENTAL HEALTH SERVICES COORDINATION: WORKING TOWARDS UTOPIA

INTRODUCTION

In 1980, 1.5 million adults with chronic mental disabilities had access to stable community living (1, p. 3400). Every day the numbers increase. The three out of four individuals who were treated as inpatients in 1955 are now treated as outpatients (1, p. 3400). States and localities continue to build on the knowledge that many mentally ill, who once would have known isolation in a state hospital, can and do live more productive lives in the community.

Yet for certain groups, most notably the seriously and chronically mentally ill, the community-based mental health system can be more of a "non-system." Its multiplicity of governmental units and mental health care providers can and often do operate independently of and in competition with each other.

And for the mentally ill individual who has been able to forge a tenuous life for himself in the community, this lack of system coordination can have direct consequences. He may visit a psychiatrist for medication management, be involved in a day treatment program directed by a social worker, and live in a halfway house supervised by a residential director. The psychiatrist, the social worker and the residential director may all provide services to meet discreet needs, but none may be ultimately responsible for the patient's welfare. He may or may not have a case manager to help him negotiate these separate service components (2, p. 10).

He could end up in the state hospital if he finds himself without appropriate crisis assistance in a time of trouble. If he remains in that long-term care environment for more than a brief period, he could lose his government benefits, his place in the day treatment program and his housing. Once he is released from the state hospital, he may or may not receive the help he needs to begin rebuilding his life. A scuffle with local police may land him in the county jail or back in the state hospital. Or if he were released to no one and no where in particular, he may soon find himself on the streets.

DEINSTITUTIONALIZATION AND THE COMMUNITY MENTAL HEALTH CENTER: THE TOUGH TASK OF DELIVERING A BETTER FUTURE

The promise of the deinstitutionalization movement of the 1960s and 1970s was a better life for the mentally ill. The new community mental health centers (CMHCs) were viewed as a central element in this better life. Yet many unforeseen problems have plagued both the dream of deinstitutionalization and the effectiveness of the CMHCs during the last two decades.

While many laudable examples do exist of community mental health systems that offer a genuine and comprehensive alternative to institutionalization, confusion was far too often the result of deinstitutionalization. Uncoordinated planning efforts between federal, state and local governments contributed to this confusion. Such efforts resulted in deinstitutionalization policies and practices that often did not fully account for existing private, quasi-public and public mental health service providers, or how they could work together to ensure a continuum of community-based services linked to the CMHC.

The federal Community Mental Health and Mental Retardation Centers Construction Act of 1963, which threw federal support and dollars behind the new CMHC approach, officially outlined many of the ideals of deinstitutionalization. State deinstitutionalization programs were soon to follow and the stage was set for several key coordination problems.

Uncoordinated Care Between the Hospital and the Community. The CMHC was to be the hallmark of a "bold new approach" in mental health care, substituting "comprehensive community care for custodial institutional care" (1, p. 3380). As such, the CMHC was basically a new treatment entity designed to supplant the old state hospital.

- Its scope would be geographically rather than clinically determined, covering a catchment area of 200,000 to 250,000 people.

- It was envisioned not only as a place, but as its own self-contained, comprehensive system of care that would eventually assume total responsibility for the mental health needs of the citizens in its "catchment" area (3, p. 762).

As the network of CMHCs would eventually replace the state hospital system, efforts to integrate the two systems became of secondary importance to the task of getting the new treatment centers established and relocating state hospital residents. The hospitals were not assigned any definite place in the interlocking matrix of community care systems. Moreover, as the ideal CMHC would theoretically assume the task of aftercare planning, many state hospitals discontinued their aftercare planning programs (4, p. 497). Thus the stage was set for frequently uncoordinated care between the hospital and the community.

Treatment Gaps and the Need for a Continuum of Care. The CMHC approach was largely based on a public health model of prevention. The successful development of anti-psychotic medications, combined with a new treatment philosophy that stressed integration rather than isolation of the mentally ill, had infused the mental health establishment with a new optimism about the future of mental health care. The hope was that CMHCs could eventually be used to limit the incidence and severity of mental illness.

Several widely-held beliefs about the nature of mental illness had contributed to this optimism about the effectiveness of the CMHCs.

- Many still believed that "all mental disorders, including schizophrenia and manic depressive psychosis. . .were caused by aberrant early childhood experiences" (5, 11), and thus were largely treatable by traditional psychotherapy that helped patients come to understand themselves.

- Social conditions such as racism and poverty were often cited as causes of mental illness, so "treating" mental illness would involve eradicating these unhealthy social conditions (5, p. 11).

- The state hospitals themselves were seen as "[contributing] largely to the chronicity of the patients' disturbance and [making] them increasingly dependent on the State Hospital for survival" (1, p. 3377), so merely transferring the patients to a more hospitable environment might improve their condition.

While the research of the last decade has largely indicated that serious mental illnesses are brain diseases, like Multiple Sclerosis and Alzheimer's disease (5, p. 12), and has done much to dispel the notion of "curing" the chronically mentally ill, such a general understanding did not exist at the beginning of the deinstitutionalization movement. The CMHCs were going to be the country's "main line of defense in reducing the need of many persons with major mental illness for prolonged or repeated hospitalization" (1, p. 3379).

As a result of the belief that, through community-based care, "the development of more serious mental breakdowns [could] be prevented" (1, p. 3379), many CMHCs simply failed to develop plans for the difficult-to-treat client. The CMHCs' failure to recognize the needs of the difficult-to-treat populations was evident in the treatment settings they established. Community treatment generally involved loosely constructed programs divided among various service providers. Such programs are often inaccessible to the seriously mentally ill, who have trouble handling stress and negotiating service bureaucracies (6, p. 15-16).

Many seriously mentally ill patients who still were, and probably would always be, in need of the diverse services traditionally supplied by the state hospital, were thus released to communities with no functional alternatives to those services. Treatment gaps began to appear in the service continuums that the local mental health programs were supposed to provide. The tenacious problems of the more chronic clients, which proved unresponsive to mere changes in treatment setting, widened these gaps.

For a variety of reasons, many states and communities were slow to recognize--and to coordinate the services to meet--the long-term care needs of those mentally ill whose needs could not be met by the traditional CMHC.

- State mental health planners, who had to make the transition from planning for the intact communities of the state hospitals to planning for a network of widely scattered community-based services, were already facing a greatly complicated task (1, p. 3401).

- Many communities had their hands full trying to coordinate the services their CMHCs could provide. Even those mentally ill who were perfectly capable of functioning in the community required a good deal more than mere mental health treatment. They needed an appropriate place to live, as well as support and general social services. These included case management, socialization programs and vocational rehabilitation and employment assistance. Unforeseen turf battles among service providers and scarce resources plagued efforts to provide this care.

- It was unclear who had ultimate responsibility for the welfare of the mentally ill whose needs could not be met by the community mental health systems. Some argue that many CMHCs shied away from responsibility for the seriously mentally ill because their needs were often so great "that properly providing them with treatment and care would make it extremely difficult for CMHCs to effectively serve other groups or carry out their other important missions" (1, p. 3404). Others believe that "from the beginning...the 'bold new approach' [of the CMHCs] was being used primarily for psychotherapy on patients with interpersonal problems, and that the patients with serious mental disorders were being ignored" (5, p. 13).

What might have led to a reinstitutionalization of many mentally ill was stopped by another phenomenon. Accompanying the deinstitutionalization movement was a movement to protect the rights of the mentally ill during involuntary commitment proceedings. States began to legislate maximum commitment periods and to put legal safeguards in place that made involuntary commitment more stringent. Key court cases, such as Wyatt v. Stickney and Donaldson v. O'Connor, mandated minimum levels of care in state hospitals, as well as treatment settings that were the "least restrictive" (5, p. 16).

As a result, even those mentally ill who could benefit from inpatient care were forced to remain in the community or become part of the "revolving door" syndrome, cycling back and forth between the hospital and the community. Recent state efforts to liberalize involuntary commitment laws indicate that the debate over patients' rights in this area is still very much alive.

Funding Patterns Complicate Coordination Issues. The various funding strategies and patterns of the deinstitutionalization movement often ended up encouraging uncoordinated, incomplete care of the mentally ill living in the communities.

- States were not nearly as willing--or able--to shift resources to the communities as they had been willing to shift patients. Many states found it politically difficult to close their state hospitals; as a result, the fixed costs of running the hospitals remained high. Many states felt a continuing obligation to the communities in which the large state hospitals had been major employers and revenue sources (3, p. 764) and were reluctant "to confront the politically powerful state employees' unions" (5, p. 18).

- When the money that had been used to support the patients in the state hospitals did not follow them into the communities, the communities had fewer dollars to establish the programs that would necessarily be a part of a continuum of care. More mentally ill began cycling in and out of the state hospitals, thus perpetuating the need for the hospitals and their continued financial support.

- Inflation began to escalate the costs of state hospital care. The number of patients receiving inpatient care decreased, but mental health dollars spent on such care ran an increasingly ragged race with the national economy. In addition, the nature of the hospital populations changed. Those mentally ill that remained in or were readmitted to the state hospitals generally had more serious and chronic problems, requiring more intensive--and expensive--care.

- Federal Medicare and Medicaid programs, as well as many insurance programs, generally did not provide reimbursement for many of the social services needed by the chronically mentally ill living in the communities (7, p. 390). Thus local governments, unable to support the costs of such social services, began to focus more on providing reimbursable medical services rather than on providing a continuum of care.

- Federal support for the mentally ill living in the communities constituted a powerful inducement for states to "dump" their mentally ill out of the state hospitals, where they were the state's financial responsibility, and into the communities. Following the passage of the federal 1963 CMHC legislation, the mentally ill became eligible for federal Aid

to the Disabled (later incorporated into the Supplemental Security Income Program), Social Security Disability Insurance, select Medicare and Medicaid benefits and Food Stamps (5, p. 15).

- The goal of the 1963 legislation--to provide "seed money" for the establishment of CMHCs until states, localities and third-party reimbursement programs could pick up the costs--proved to be particularly elusive. Subsequent amendments to the federal legislation extended support to the CMHCs considerably beyond the point originally intended. In 1970, for example, by increasing the federal share of center construction costs, the Congress concluded that "earlier optimism regarding the progressive development of funding resources . . . proved to be too optimistic" (1, p. 3384). Moreover, it became increasingly clear that "localities in the greatest need of community-based mental health services . . . [had] been least able to organize, plan and raise sufficient funds" (1, p. 3384).

Later Problems. In addition to the initial problems that discouraged coordinated care for the mentally ill in the community, other trends during this decade have complicated those problems.

- Federal funds for social and mental health services have decreased dramatically. The federal Mental Health Systems Act of 1980, for example, which authorized grants for a variety of purposes related to community mental health care, was largely repealed in 1981. Competition for the remaining funds among state and local social service agencies has increased, augmenting existing pressures to protect agency turf and increasing resistance to interagency communication and cooperation.

- In 1981, administrators of the Social Security Disability Insurance program were ordered to begin regularly reviewing the eligibility of beneficiaries. As a result, benefits were terminated for a large number of mentally ill individuals who were dependent on the income to meet basic needs. These changes compounded coordination problems already posed by the lack of syncronization between federal assistance programs and state hospital discharge policies, which often result in patients being discharged without benefits (1, p. 3410).

GENERAL LEGISLATIVE GUIDELINES

While states cannot remedy all the problems wrought by the deinstitutionalization policies of the past, they can do much to ensure a future of coordinated care. Possible areas for legislative action include:

- Requiring or encouraging coordinated planning through interagency agreements and guidelines;

- Restructuring the state's mental health administrative branch in order to facilitate coordination;

- Delegating the specific authority to coordinate mental health services by delineating leading and supporting roles among state agencies, and by extending the mandate to include all the agencies involved;

- Authorizing local mental health authorities to develop a more comprehensive system within the existing state system;

- Identifying priorities related to coordination;

- Monitoring and directing coordination efforts through the budget and appropriations process by tying state funds to the provision of specific or priority mental health services (8).

States can also act to ensure that coordination mechanisms are in place by working to incorporate the system elements that are basic to many successfully integrated community mental health programs:

- A theoretical basis for the service system;

- A single plan for provision of services;

- A single point of funding allocation;

- A fixed, local government entity with authority for and responsibility to provide services in a given area;

- A designated port of entry and exit into the public mental health system or, at least, into the state hospital system;

- A no-refusal policy among all system elements;

- A flexible policy that can respond to the unique needs of the patients;

- A patient tracking system that keeps patients from being "lost" (9, p. 108-09).

THE STATES' RESPONSE IN RECENT YEARS

State lawmakers have attacked the problem of uncoordinated care for the mentally ill from a variety of angles. As a first step, legislation can be very effective in identifying and combating coordination problems. Legislation directly related to coordination of mental health services has already been introduced this year in Arizona, Mississippi, New York, Oklahoma and Tennessee. Many other states have addressed this issue in recent years.

A number of states have worked to establish an interlocking matrix of local programs tied together by a central mental health authority or by some kind of statewide plan for mental health services. The following are examples:

- Florida (Fla. Stats. § 230.2317) established a state wide network of service districts for the treatment of mental illness and substance abuse overseen by a network of planning districts;

- Georgia (1976 Ga. Laws, p. 1136) provided for the development of a state wide plan for provision of coordinated mental health services by establishing community mental health and mental retardation service areas overseen by advisory councils;

- Iowa (1981 Iowa Acts, chap. 78) centralized administrative authority for mental health in the state Division of Mental Health, Mental Retardation and Developmental Disabilities, and directed counties to establish county mental health and mental retardation coordinating boards;

- Washington (1982 Wash. Laws, chap. 204) defined the roles of the state, the counties and the individual service providers in the state mental health system and delineated responsibilities for a continuum of care and coordination.

Similarly, New York (N.Y. Ment. Hyg. Law § 41.19, 41.21, 41.23) and Wisconsin (Wis. Stats. § 54.12 and 54.437) both made use of the "unified services" concept, which aims to integrate the various mental health services provided in a given region, in their states' blueprints for mental health services. Wisconsin required each county to develop a unified services plan for its catchment area. New York offered--and five counties accepted--the option of developing such comprehensive plans. In the same vein, North Carolina (1983 N.C. Sess. Laws, chap. 348) gave locales the option of adopting single port of entry/single exit systems in their provision of mental health services.

Some states have attacked the problem of uncoordinated care through the creation of coordinating boards or councils. Minnesota (1985 Minn. Laws, chap. 252) established a state mental health planning council to advise on matters relating to coordination. Nevada (1985 Nev. Stats, chap. 672) established its state commission on mental health and mental retardation, in part to coordinate services on a statewide basis.

Similarly, Texas (1983 Tex. Gen. Laws, chap. 308) established the Texas Health and Human Services Coordinating Council to develop procedures for ensuring coordinated care between the state's human service agencies, including those involved in providing services to the mentally ill. The work of the Coordinating Council helped prompt passage of a 1985 bill (1985 Tex. Gen. Laws, chap. 496) mandating the development of a long-range plan for mental health services and the provision of certain minimum services in each service area.

Still other states have directed considerable effort towards bridging the gap between the hospital and the community. The following are examples:

- Arizona (1984 Ariz. Laws, chap. 127) established an Arizona State Hospital Advisory Board to help devise goals for the state hospital and to offer advice on the coordination of services, programs and policies between the state hospital and the community mental health care programs;

- Illinois (1985 Ill. Laws, p. a. 84-918) aimed to secure and maintain adequate financial benefits for those individuals admitted to, and released from, the state hospital by requiring interagency agreements to that effect;

- Oregon (1981 Ore. Laws, chap. 750) required agreements between community mental health programs and the state hospitals to ensure a continuum of care for patients admitted to, and discharged from, the state hospitals.

Select states have also targeted certain priority populations or services in their efforts to build an integrated system. At least four states, for example, have passed legislation consolidating administrative authority and responsibility for services to mentally ill children: Connecticut (Conn. Gen. Stats. § 17.410 - 17.447); Delaware (Vol. 64 Del. Laws, chap. 108 (1983)); New Hampshire (1983 N.H. Laws, chap. 416); and Rhode Island (1979 R.I. Pub. Laws, chap. 248). Michigan (1984 Mich. Pub. Acts, act 186) took a slightly different

approach when it established a single port of entry/single exit system for mental health services to children and standardized treatment procedures throughout the state.

California consolidated its services to the homeless mentally ill by requiring the establishment of at least six social support agencies to coordinate comprehensive mental health and social support services for the homeless mentally ill on a regional basis (1985 Cal. Stats, chap. 1286).

Moreover, a number of states have paid significant attention to the coordination and development of adequate community-based residential services. For example, Hawaii (1980 Hawaii Laws, act 221; 1985 Hawaii Laws, act 219) provided guidelines for the establishment of a statewide system of residential treatment programs that provide a range of alternatives to institutional care for the mentally ill. New York (1984 N.Y. Laws, chap. 298) authorized the commissioner of mental health to establish a continuum of community residential services for the mentally ill, providing up to 100 percent state reimbursement of costs associated with these residential programs.

FUTURE IMPLICATIONS

Federal money to the states for general mental health and social services probably will continue to decrease. States will thus be forced to spend more of their general mental health budgets on supporting the state hospitals, unless they take definitive action to tranfer funds and authority to the local governments already responsible for caring for the vast majority of the nation's mentally ill.

Local governments probably will become increasingly unwilling--and unable--to bear the ultimate responsibility for the mentally ill living in their communities as more federal funds are drained from their local programs. In addition, states must be realistic about what a future of fiscal austerity promises for a system made up of discreet service agencies all vying for their own survival. Turf battles between the agencies involved in the community-based mental health system can only increase as competition for available funds increases. These agencies probably will become increasingly resistant to working together if such cooperation is perceived as a threat to their financial survival as well as to their administrative autonomy.

Yet a future of increasing admissions to state hospitals and decreasing cooperation among mental health providers is far from inevitable. In the 1970s, for example, Wisconsin effectively recast its mental health system from one of institutionally-based care to one of locally-based care. This redirection effort involved the development of unified services plans for each catchment area, of community support programs and of alternatives to inpatient hospitalization for persons in crisis. State legislation shifted treatment authority and responsibility to local mental health boards.

Moreover, every state has at least some success stories of community-based programs that genuinely offer the mentally ill a better, more productive life. State legislatures can help build a better future for this population by learning the lessons of success from within their own borders, as well as from other states.

MISSOURI AND PENNSYLVANIA: CASE STUDIES OF MENTAL HEALTH COORDINATION PROBLEMS

INTRODUCTION

Many states have had trouble making the dream of locally-coordinated care for the mentally ill a reality. Most still spend a disproportionate amount of their mental health budgets on their state hospitals, while the majority of their mentally ill live in the community.

Missouri and Pennsylvania received the assistance of the NCSL Mental Health Project on coordination issues. Missouri expressed concern over specific types of coordination problems. Pennsylvania expressed concern over a larger coordination issue: the state hospital's revolving door, especially as indicated by the increased incidence of homelessness among the mentally ill.

The Missouri and Pennsylvania technical assistance programs were conducted in September and October 1985. The coordination problems discussed for each state were outlined by legislators and staff involved with mental health issues in their state. The suggestions provided reflect the opinions of the consultants involved in each program and do not necessarily reflect those of NCSL or the National Institute of Mental Health.

Consultants for the Missouri program included Dr. Anthony Broskowski, Northside Community Mental Health Center, Tampa, Florida, and Dr. Robert Agranoff, School of Public and Environmental Affairs, Indiana University, Bloomington, Illinois. Consultants for the Pennsylvania program included Dr. David Goodrick, Alpha Center, Washington, D.C., and Dr. Dana Mausch, Executive Director, Mental Health and Community Support Systems, Rhode Island Department of Mental Health, Retardation and Hospitals, Providence, Rhode Island.

MISSOURI: TRANSLATING COORDINATION POLICY INTO PRACTICE

Missouri legislators and staff outlined the following key coordination issues for their state: establishing continuity of treatment for children and youth; providing adequate vocational rehabilitation services that are necessarily a part of a community program's continuum of care; and preparing for the possible implementation of some type of prospective payment system, so as not to exacerbate existing coordination problems.

Children and Youth Prescriptive Teams. Missouri is currently exploring the feasibility of adopting multi-agency "prescriptive teams" for mentally ill children and youth on a statewide basis. At the present time, two such teams are operating on a trial basis in Jackson County and St. Louis City/County. These pilot teams have two primary goals: to gather information on what problems inhibit the provision of effective care and treatment for Missouri's mentally ill children and youth and to provide services to children referred to the teams to test their effectiveness as a treatment model.

To date, the treatment teams have encountered the following structural problems, which inhibit their optimal functioning:

- A confusion over which state or local agencies are ultimately responsible for the children referred to a team;

- A lack of the statutory authority, funding or placement ability that would allow the teams to prescribe and carry out the best treatment plans for the children and youth;

- A system orientation that favors the services presently available and that allows for large gaps in the service system needed to treat children with special needs;

- Agency rules, combined with incentives for keeping children in expensive and restrictive treatment programs, that prevent the teams from exploring creative treatment alternatives;

- Communication problems between the agencies involved in treating the children, arising from such sources as agency-specific jargon, confidentiality of records and improper documentation of how and why a child's past treatment programs have failed.

Specifically regarding the prescriptive teams, Missouri could consider the following changes:

- Developing a more formal process that would allow the teams to collect data on clients, their various service and treatment needs, and the barriers to interagency coordination and to make this information available for interagency coordination and planning efforts;

- Requiring former service providers to give explicit information on a child's treatment history if and when the child is referred to a prescriptive team;

- Requiring the appointment of one prescriptive team member to follow through on and monitor the implementation of the child's treatment plan.

Missouri could consider the following general changes relative to services for mentally ill children and youth, taking into account the problems encountered by the teams:

- Authorizing the Missouri Department of Mental Health (or another appropriate agency) to take the lead in an interagency effort to define a continuum of care for severely disturbed youth and to develop the needed services;

- Identifying a lead agency to bear primary responsibility--and to have final decision-making authority--for the treatment of children and youth.

Competitive Employment. Missouri's mentally ill cannot be successfully integrated into the community unless they are provided appropriate employment opportunities. Yet the goal of appropriate employment for Missouri's mentally ill is often hampered by interagency problems over who is going to pay for what services, when and how.

- Prevocational and employment services have long been considered the exclusive domain of the Division of Vocational Rehabilitation, not the Departments of Mental Health or Social Services. Moreover, the guidelines established for such services under the DVR sharply limit the availability of such services to the chronically and severely mentally ill.

- Transitional employment and other pre-competitive employment services, required by the mentally ill before they can enter the working world, are difficult to obtain..

The Missouri legislature could pass legislation mandating coordination between the Division of Vocational Rehabilitation and the Department of Mental Health to ensure that the services within the domain of the DVR are made available to the mentally ill. The legislature may also want to develop policies that encourage the development of and provide support for programs that provide transitional and pre-competitive employment services for the mentally ill. Such competitive employment services should, ideally, be a right of Missouri's mentally ill.

Prospective Payment Systems and Diagnostic Related Groups. Diagnostic Related Groups (DRGs) are the patient classification units of prospective payment systems (PPS). PPS aim to curb unnecessary hospitalization or use of services by paying certain pre-established amounts for illnesses considered similar in terms of their use of resources for care and treatment. While psychiatric hospitals and psychiatric units of general hospitals were temporarily exempted from the PPS system adopted by the federal government for hospital care provided under Medicare, many feel that some type of cost containment measure is inevitable for psychiatric care as well. New Jersey has explored the possible impact of DRGs on psychiatric care, as well as alternative cost containment methods. Missouri wants to prepare itself as well.

- A primary problem with the DRG funding mechanism is that it may encourage secondary consideration of proper patient care, since a fixed amount will be paid for such care, regardless of the services provided.

- The development of alternatives to DRGs is costly and time-consuming, as the state must assume reponsibility for devising and testing alternative payment scales. Moreover, the federal government may not be willing to adopt such alternative measures on a single-state basis.

Hypothetically, DRGs could exacerbate certain key coordination problems because the demands of the funding mechanism could be placed before the needs of the clients. Missouri may want to explore ways to minimize the impact of DRGs on its existing coordination problems.

- DRGs can encourage the "dumping" of mental health clients from the private system into the public system, which can result in a concentration of the most extensive and difficult-to-treat clients in the public hospitals that cannot refuse admissions.

- Hospitals may discharge patients prematurely, treat clients with multiple problems for one problem at a time, or avoid necessary consultation with specialists in order to maximize the DRG reimbursements.

To ensure that the treatment needs of the clients come before the mechanisms of the DRG system, Missouri could do the following: provide services on a pre-paid basis that are adequate to cover all necessary services and all service groups, including high risk and high disability groups; ensure that service provider groups are small enough to allow for a familiarity with each client, so that coordination can go on among the heads of the service agencies; and consider adopting a Health Maintenance Organization (HMO) model in which

service providers are encouraged to work together to maintain the greatest possible level of health.

PENNSYLVANIA: THE BASICS OF COORDINATION

Pennsylvania expressed concern over a basic coordination problem that has come to plague many states in the aftermath of deinstitutionalization: the state hospital's revolving door, especially as indicated by the increased incidence of homelessness among the mentally ill. Pennsylvania's deinstitutionalization history is not unique. Moreover, in 1985, the Pennsylvania Legislature passed a Senate Resolution (S.R. 108), providing for a review of the state's mental health system.

Pennsylvania's Mentally Ill: How They Came to be Caught in the State Hospital's Revolving Door. In 1966, Pennsylvania had 35,000 patients in its state hospital system; in 1985, about 8,200 mentally ill Pennsylvanians resided in the state hospital. In spite of this deinstitutionalization of nearly 27,000 state hospital residents, the State Division of Mental Health still spends only $250 million of its $750 million dollar budget (including medical assistance payments) on community-based care (10). While the state has made considerable progress in shifting its mental health resources to the community, this disparity between the location of mental health funds and mental health patients is the basic structural element upon which the state hospital's revolving door turns. The following statistics from Philadelphia indicate that the problem promises to increase.

- Philadelphia State Hospital, serving the state's largest urban area that contains roughly one-quarter of the state's mental health clients, admits/discharges slightly under 500 patients per year, with nearly half of the discharged patients readmitted within one year (11).

- The Philadelphia County Office of Mental Health and Mental Retardation, which serves the same urban area, admitted 62,000 people--24,000 of whom required some kind of inpatient care--in 1984. Four hundred and fifty were involuntarily committed to the Philadelphia State Hospital (12).

- Between 1983 and 1985, the Philadelphia County Office of Mental Health and Mental Retardation witnessed a dramatic increase in the number of admissions to public psychiatric emergency rooms from 19,000 to roughly 30,000. Studies have found that the group, which is increasingly utilizing psychiatric emergency services, is composed of individuals who are primarily 18-35, have never been in the state hospital system, and have often been deemed treatment resistant by the CMHC system (12).

Dismantling the Revolving Door: Possible Solutions. Community mental health programs that spend the least amount of their budget--or the state's--on inpatient care are invariably in communities that offer a broad range of services to individuals who have been stabilized in the community and to those individuals in crisis. Communities that have not been aggressive about developing alternatives to inpatient care tend to pay the highest inpatient costs.

Pennsylvania is already taking significant steps to help eliminate the state hospitals' revolving door. Yet the state may want to consider increasing its present efforts in the following areas:

- Moving the mental health system towards a community care foundation and away from a basic structural focus on inpatient care. Such a shift would involve transferring the funds and authority to provide necessary services to the communities;

- Establishing community support programs, including mobile treatment teams, to provide such services to the mentally ill as crisis intervention, case management, medication monitoring and residential programs.

Moreover, the state may wish to consider establishing a "resource envelope" for the mentally ill. Such an envelope would involve legislators and state and local mental health directors examining mental health clients, funding, staff and responsibility and authority for local mental health programs in an integrated way. When resource envelopes are adopted, very often community programs are chosen as the most cost efficient and effective means of treating a client.

The Mentally Ill Homeless as Victims of the Revolving Door. In June 1984, the Pennsylvania Legislature passed House Resolution 249, establishing a committee to review the problems of homelessness. The committee conducted hearings across the state and submitted its final report in November 1984. The report cited homelessness among the mentally ill as a high priority problem for the state, requiring special attention.

Pennsylvania could do much to allay the problems of homelessness among the mentally ill by increasing its present efforts to tranfer funds and authority for mental health care to the communities. But Pennsylvania must also consider that the homeless mentally ill are victims of other revolving doors that the state must act to close as well if it wishes to decrease homelessness among this group.

- The mentally ill are often in and out of entitlement benefit programs. While recognizing that the regulations controlling federal assistance programs pose certain roadblocks, Pennsylvania may want to accelerate its efforts to ensure income maintenance benefits for those mentally ill who are briefly rehospitalized and work to secure presumptive disability benefits, similar to those provided to prisoners, to enable a mentally ill individual to receive two or three months of general assistance following a longer hospitalization.

- The mentally ill are often in and out of housing programs. Pennsylvania may want to increase its efforts to protect the mentally ill against discrimination in public housing and work to increase the "set-asides" made for the mentally disabled in public housing projects. The state could also expand emergency assistance programs for back rent and utility arrearage programs for the mentally ill. Pennsylvania may also want to accelerate its effort to bring both housing and mental health interests together to solve the problem of emergency, transitional and permanent housing for the mentally ill homeless.

- The mentally ill are often in and out of support programs. Beyond working for a continuum of care, Pennsylvania may also want to increase its efforts to provide continuity of care, so that the mentally ill individual can develop a stable relationship with both mental health programs and personnel.

- The mentally ill are often in and out of mental health programs. Pennsylvania may want to consider some type of return to the field approach to mental health care to ensure that the mentally ill cannot easily fall through the cracks of the local care systems. CMHCs need to adopt more aggressive outreach and population-tailored treatment programs for the homeless mentally ill, including providing mental health and emergency medical services in shelters, etc.

CONCLUSION

Both Missouri and Pennsylvania need to continue to address the fact that coordinated care for the mentally ill may be difficult to achieve as long as different entities provide the funding for mental health services and the actual services. Without giving specific units--be it prescriptive teams for children and youth, or the local CMHC--the responsibilty and authority for treating those mentally ill within its domain, efforts to provide the neccessary services may be hampered. And both the states and the mentally ill will pay.

Yet both states already have made significant strides towards a comprehensive and integrated system of mental health care. Coordination efforts within and between select service delivery components in these two states have already brought about improvements in the care and treatment of the mentally ill. These improvements augur well for a future of increased integration, acceptance and appropriate treatment for this most-in-need population.

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TECHNICAL ASSISTANCE PROGRAM TAPES AND BACKGROUND MATERIALS

Available through the NCSL Mental Health Project are edited tapes of the actual technical assistance program presented for Pennsylvania in October 1985, as well as the background materials distributed at both the Missouri and Pennsylvania programs.

The tape of Pennsylvania's technical assistance program, entitled "The Revolving Door Syndrome of Mental Health Services," features Dr. David Goodrick, Alpha Center, Washington, D.C., and Dr. Dana Mausch, Rhode Island Department of Mental Health, Retardation and Hospitals, Providence, Rhode Island. Dr. Goodrick addresses the question of whether or not there is a revolving door in the mental health system. Dr. Mausch addresses the question of whether or not the homeless mentally ill are victims of that revolving door. Both speakers present specific suggestions for Pennsylvania.

Background materials relating to mental health services coordination (Missouri) and to the revolving door in mental health services (Pennsylvania) include a summary of select state legislation, a discussion of model programs, a bibliography and a checklist that interested legislators and staff may return for copies of legislation and bibliographic materials.

If you wish to receive loan copies of these tapes, or the background information distributed at the technical assistance programs, please copy, complete and return the form below to the Mental Health Project, NCSL, 1050 17th Street, Suite 2100, Denver, CO 80265.

Name: _____

Title: _____ _____

Address: _____

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Requesting Missouri background materials ___

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